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ABSTRACT

Intended primarily for use by Unicef colleagues working in program communication and training, this handbook gives a general overview of the "building blocks" needed for putting together the communication component of a development program. To do this, the handbook uses as an illustrative example the development of a communication strategy for an expanded program of immunization. Following introductory material, the handbook deals with the identification of audiences to be reached in an expanded program of immunization, an analysis of the constraints on the participation of different audiences, the selection of appropriate media for different groups and different purposes, and the overall communication strategy development. The handbook concludes with a summary of the main points of the advocated communication program approach and a glossary of terms used. Accompanying the handbook are reference materials drawn from actual communication/training situations that can be used in further briefing and training exercises, including materials on program communication, key questions on developing a program communication strategy, indicative and communication matrixes, monitoring and evaluation, and slide shows. (EL)

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HANDBOOKS in COMMUNICATION and TRAINING for CSDR

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PROGRAMME COMMUNICATION

A Handbook on Communication Strategy Development for Child Survival and Development Programmes

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PSC and Training Section

UNICEF
East Asia and Pakistan Regional Office
Bangkok, Thailand

CS 505 223

WHO
SAYS WHAT
IN WHICH CHANNELS
TO WHOM
WITH
WHAT EFFECT

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FOREWORD

The introduction of a new series of EAPRO Handbooks on Communication and Training for the Child Survival and Development Revolution (CSDR) merits a word or two of explanation as to their intended use. These handbooks are primarily for use by UNICEF colleagues working in programme communication (PSC) and training, all of whom spend a considerable time explaining and advocating their approach to new staff, to UNICEF programme colleagues and to other audiences in government or non-government agencies.

The handbooks are also hopefully a means whereby colleagues who use them can learn from each other more about any areas of this very wide and diverse field which may be new to them.

Accompanying each handbook will be reference materials drawn from actual communication/training situations which can be used in further briefing and training exercises. It is hoped that colleagues will contribute more examples from their own direct experience, and from their files.

Handbook One on Programme Communication gives a general overview of the development and implementation of a programme communication strategy. The examples used throughout are taken from a typical Expanded Programme of Immunization (EPI). Shorter booklets illustrating the same approaches, but with examples taken from Oral Rehydration Solution (ORS) Promotion, Breast-feeding Campaign, development and use of the Growth Chart, Communication for Water and Sanitation Programmes and other major programme themes are also under preparation.

In the text of the present handbook we refer to companion papers, also being produced. The projected publication list presently includes specific papers on:

- Social Marketing
- Audience Identification and Analysis
- Media Selection
- Production Techniques
- Media Testing
- Training Methodology
- Monitoring and Evaluation

Suggestions for other useful items -- or contributions of drafts on these or new areas -- will be gratefully received!

Similarly, we would also like to hear any comments or queries you might have about these publications.

Jane Bunnag-Haile

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January 1985

INTRODUCTION

The purpose of this introductory paper is to discuss in general terms the basic "building blocks" needed for putting together the communication component of a development programme. We shall, however, use as an illustrative example, the development of a communincation strategy for an Expanded Programme of Immunization (EPI).

Programme or Development Communication goes under many different names according to agency and sectoral concern; in UNICEF, it is Programme Communication; in UNDP and FAO, DSC --Development Support Communication; in many "population" agencies it is more frequently, known as IEC -- Information, Education, Communication.

Within the bounds of this paper we shall not discuss these different brands of development communication, nor their history. Treatment of some of these concerns can be found in the accompanying reference materials as well as being reflected in later handbooks.

"The priority audience is parents and particularly mothers."

1. IDENTIFICATION OF AUDIENCES TO BE REACHED

A key word in programme communication is "AUDIENCE"; used often confusingly to indicate primary beneficiaries of a development project -- typically mothers of young children in UNICEF's case -- as well as other interest groups whose informed support is necessary at various times, and at various levels if the project is to proceed as expected.

A programme of communication for EPI might, for example, involve establishing a dialogue with some or all of the "AUDIENCES" in our "onion ring" below; we shall refer again to this vegetable. We can say that the programme communicators' primary concern is to see that the concerns and interests of the various AUDIENCES are properly taken into account in both the programme or "service-delivery"* side, and in the more strictly communication or "demand-creation" aspects*.

Let us give a couple of examples of this: First, from the nutrition field: a programme communicator would be disinclined to use in his village-based communication a typical nutrition chart -- with the usual "cake" sliced into proteins, fats and carbohydrates, however, technically accurate and beautifully produced. He would be more likely if developing visual aids on this theme to use actual illustrations of locally available foods, grouped into balanced meals for particular age-groups. Hence, the communicator and nutrition programme officer can perfectly complement each other. The former helping the latter to convey the same information in the terms the AUDIENCE of village mothers can readily understand and hopefully implement.

How would we then identify our AUDIENCES for an EPI? The priority AUDIENCE is parents, and particularly mothers, if we are to assume that they take a major responsibility for child care, of children in the ages 0-5; and pregnant women who should be immunized against neo-natal tetanus, which vaccination is also included in the EPI package.

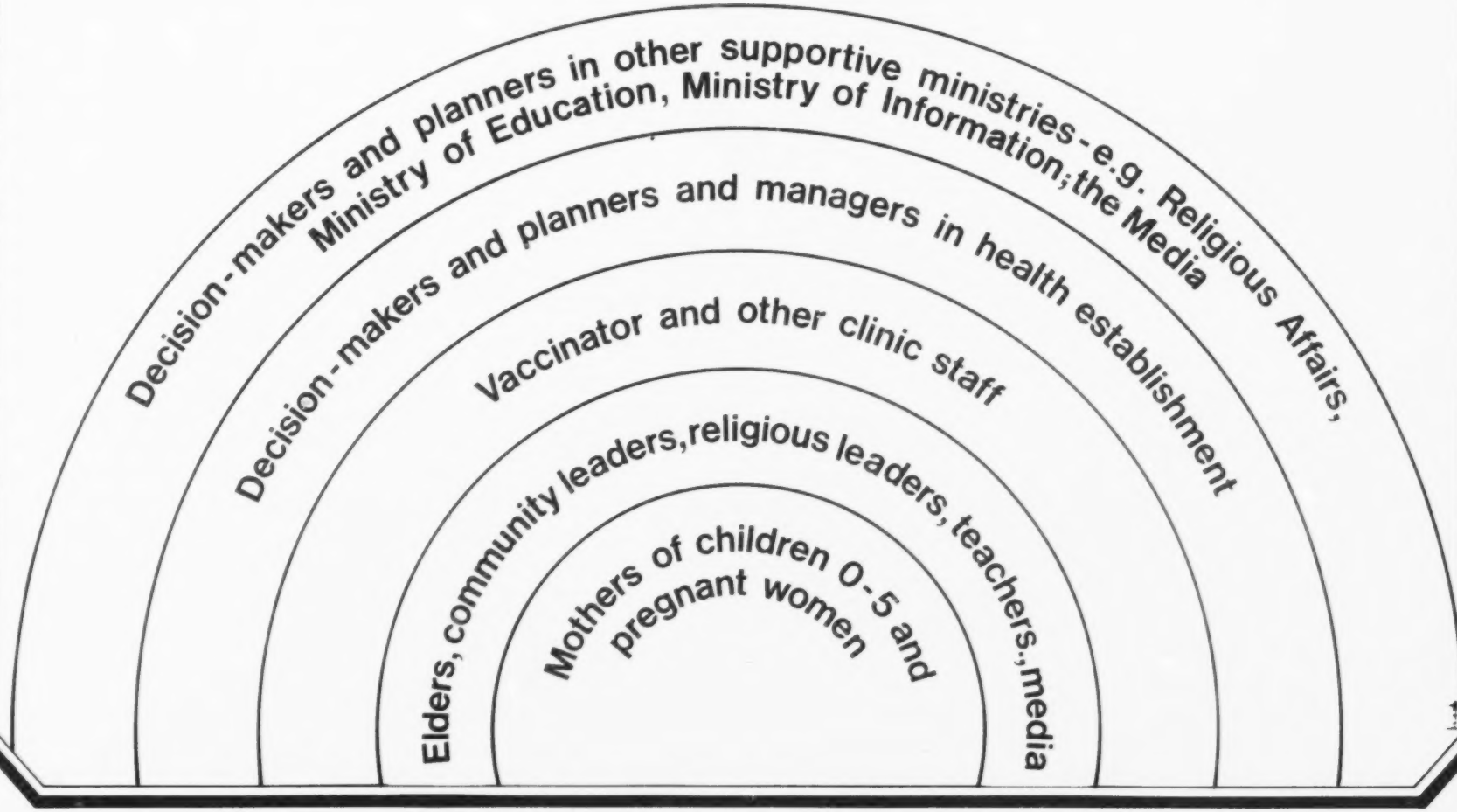
The behaviour required of this group is that they should bring their children for the full schedule of vaccinations; and be immunized against neo-natal tetanus in the case of pregnant women. An important supportive AUDIENCE to this group are the people with whom they interact daily and who influence decisions; typically senior relatives -- grandmothers "satisfied acceptors" of vaccination; and other community leaders, imams*, school teachers, etc., whom we would also include this group. These people may introduce and/or encourage new thinking and behaviour patterns among the priority groups who are actually responsible for decisions about child care, when convinced themselves.

The next important audience to be considered are the front-line health-staff and vaccinators who should not only know how to provide the services, but also how to communicate the needs for and benefits of immunization in such a way as to convince the mothers, or future mothers, and to banish their fears and concerns.

In general, interpersonal media -- also known as "people"! -- if well-informed and motivated are regarded as being the most effective in influencing our primary AUDIENCE, and, hence, from the development communicators' point of view are themselves an important secondary AUDIENCE to be informed about the programme and encouraged to inform and involve the "target group".

* See glossary of terms

IDENTIFICATION OF AUDIENCES FOR AN EXPANDED PROGRAMME ON IMMUNIZATION


Decision-makers and planners in other supportive ministries-e.g. Religious Affairs, Ministry of Education, Ministry of Information;the Media
Decision-makers and planners and managers in health establishment
Vaccinator and other clinic staff
Elders, community leaders,religious leaders, teachers.,media
Mothers of children 0-5 and pregnant women

Thus, we see that the development communicators' "AUDIENCES" function as channels of communication or "media" also, within the project and vis-a-vis other "AUDIENCES". This applies even to our "PRIMARY AUDIENCE" of intended beneficiaries from whom the communicator seeks response and feedback throughout the project. It is important to realize that our categories "AUDIENCE", "media" vary according to context and point of view.

Indeed, the media - narrowly defined - television, radio, newspapers, "indigenous media"* of all kinds, are another "AUDIENCE" for the development communicator. Where they are accessible and credible, especially to our community of mothers, it is very important to inform them about the programme and their potential role in enlisting support of the primary audience of mothers.

What other groups do we need to reach and to activate in order to communicate with our primary and intermediate AUDIENCES? If we are to turn vaccinators into communicators also, they will need some basic training on the programme content, as well as on how to address the questions and concerns of the mothers submitting their children for vaccination. This will involve developing additional training materials perhaps, which means ensuring that budget and expertise are authorised for that. In turn, this involves, of course, approaching decision-makers in the Ministry of Health, to ensure that modifications to the vaccinators' training course can be made and that there are trainers trained to do that. Supervisers of vaccinators must also give their informed support to this expanded role. If we are to work with religious leaders at the village level it is important to get understanding of and clearance from the higher religious authorities; similarly engaging the support of village primary school teachers typically needs the informed support of the higher authorities in the Ministry of Education; media organisations may be more, or less de-centralized.

The order in which we have presented our AUDIENCES reflects their relationship to our primary AUDIENCE for whom the project is intended -- in the case of EPI, the mothers of children 0-5 and pregnant women. Practically and chronologically speaking, however, when implementing the programme the primary AUDIENCE is often not the first AUDIENCE which we should approach. To reach them we must first address our other AUDIENCES who provide us with channels to our ultimate addressees. For example, the decision-makers in the Ministry of Health, who must authorize additional training for vaccinators to enable the latter to communicate more effectively, may be the first AUDIENCE we should reach in time.

2. ANALYSIS OF CONSTRAINTS ON THE PARTICIPATION OF DIFFERENT AUDIENCES

When the AUDIENCES have been identified the next important step is to analyze the current constraints - particularly in terms of behaviour, attitude, knowledge level -- in operation for each of these AUDIENCES, and which will inhibit their participation in the proposed programme. This analysis is a reflection of the recognition that simple provision of services --immunization programmes, sanitary latrines, etc. -- does not necessarily bring about behavioural change, and of the parallel recognition by development communicators that simple top-down provision of information about those services will not affect AUDIENCE response unless the services in question (and, hence, associated communication activities) address community interests and needs. AUDIENCE or consumer analysis should uncover these interests and needs, as well as providing information on each AUDIENCE as it is reached by, and attentive to different electronic and human media.

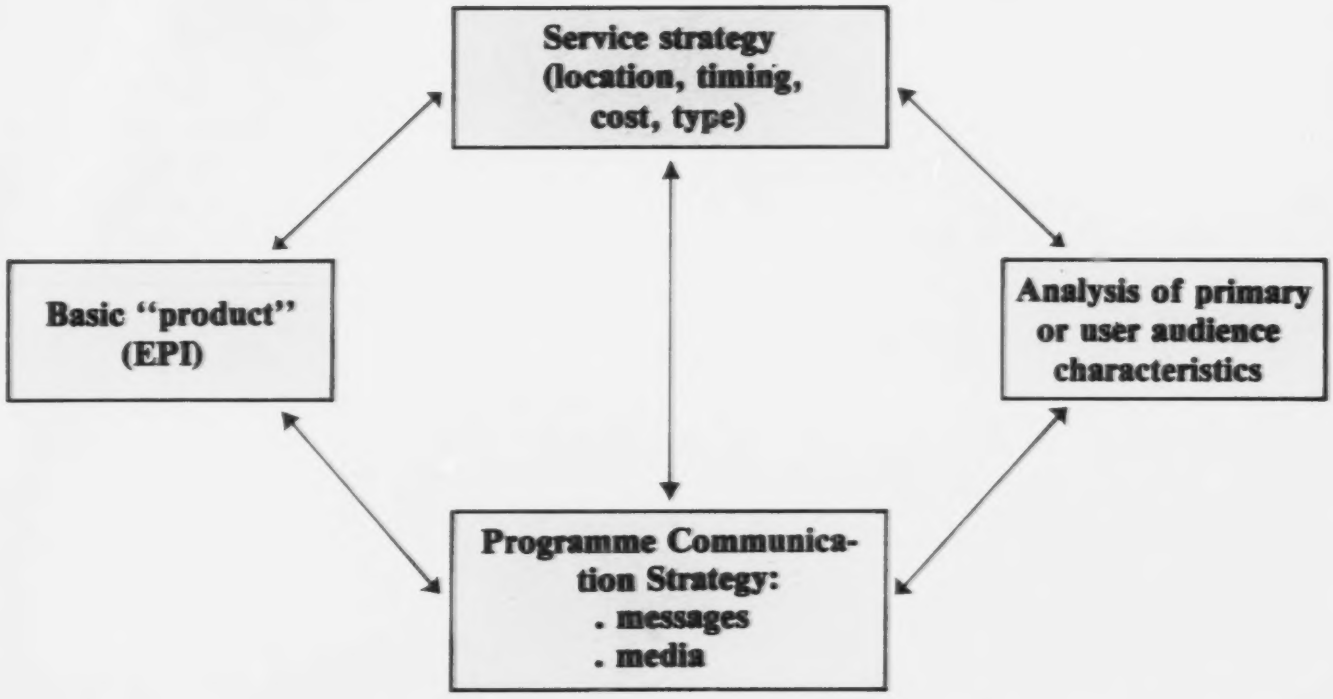
To take our example again from EPI: in beginning to determine why mothers do not submit their children for vaccination, the development communicator typically seeks the answers to a number of questions:

"Traditional child-care practices may be a powerful constraint on participation."

(a) Do mothers recognise the preventible diseases?

- do they know they are preventible?
- do they know about immunization?
- do they recognise that immunization is preventive as well as curative?
- do they know about the existence of the Expanded Programme of Immunization; the timing, location and costs?
- have they had negative experience with the programme to date?
- do they know about the schedule of vaccinations; about the possible side-effects and how to deal with them?
- Where do they get their information from, on this issue and other health-related matters -- grandmothers, village elders, medical staff, local midwives, teachers, newspapers/radio?
- how regularly do they visit the clinics where EPI is being offered; are there other and preferred sources of medical care for the community?
- can they conveniently reach the clinics during the stated hours; can they afford the services?
- do they have preference for vaccinators of one sex rather than the other?

From this typical though not exhaustive list it is clear that a thorough audience analysis goes beyound scrutiny of knowledge level and, of course, of knowledge as influencing behaviour, to economic and logistic factors. Hence, this type of analysis normally conducted by programme communicators has implications for both service and communication strategies.



This is in a sense both the strength and the weakness of the programme communicators' position when explaining what they do. Programme communication is not and cannot be a discreet area, it has fuzzy edges, in that some of this data should be, or may be collected by programme officers. Broadly, we can state that programme officers deal more with quantitative aspects of the audience, and programme communicators deal more with qualitative aspects --"with"the what (programme) and the "why"(programme communication) respectively. Programme officers would need to know about prevalence of different kinds of diseases, the mortality rates at each age; the number of children and mothers to be reached from each service point, and, hence, the number of doses of vaccine needed; previous immunization coverage; the drop-out rate for different immunization schedules. They would work also with different technical experts on establishing and managing the cold chain, on record keeping, and so forth. We can see by comparison with the questions on the previous page that these questions deal with essentially complementary aspects of the same issue; programme officers look at what the coverage is, programme communicators look at why the coverage is what it is in terms of AUDIENCE beliefs and behaviour at the present time.

This type of analysis is conducted for each of the "AUDIENCES" identified. Let us review briefly the kind of questions the development communicator would pose (b) to the lower level health staff/vaccinators with immediate access to the community; (c) to decision-makers in the medical establishment.

(b) Lower level health staff/vaccinators with immediate access to the community

- are health staff with immediate access to the community well-informed about the substance of the EPI (symptoms of different diseases, side-effects, schedule of vaccinations) so that they can communicate needed information to the mothers? Their input is particularly critical if mothers are to return to the clinic for subsequent vaccinations?
- are they aware about the mothers' fears and information needs; do they know how to address these concerns?
- have they any knowledge of communication techniques or tools (use of "satisfied acceptors")* with which to extend their own range and impact?
- are they too busy -- or do they perceive of themselves as being too busy -- to do "health education" or promotive work; to follow up on initial acceptors?
- do they have the budget, if needed, for communication work, for travel to contact people in their homes, etc.?

(c) Decision-makers in the medical establishment

- are they aware of the obstacles to the success of the programme arising from lack of acceptance by the community?
- do they know how they themselves can help to overcome this problem by strengthening health education/communication aspects, particularly by equipping service-deliverers as communicators also?
- are they aware of the value of co-operating with other sectoral ministries (community development, agriculture) in health communication activities?
- are they convinced that funds spent on these activities are well-spent?

Are decision makers convinced of the need to involve the community? Do they know how?

All these avenues must be explored during the planning process if we are to make all the connections necessary to ensure the informed participation of the user audience of mothers. The chain is only as strong as the weakest link. Let us imagine that the medical establishment agrees to strengthening vaccinators' communication capacity and makes an allocation for training; the trainers develop a communication component; the vaccinators are trained and perceive that they should take a more active role in convincing mothers of the benefits of the EPI. And yet if the constraints both in terms of lack of initial information from any source and in terms of appropriate services still keep the mothers away from the clinic, then little has been achieved. The key here is to look at communication and training as a total system.

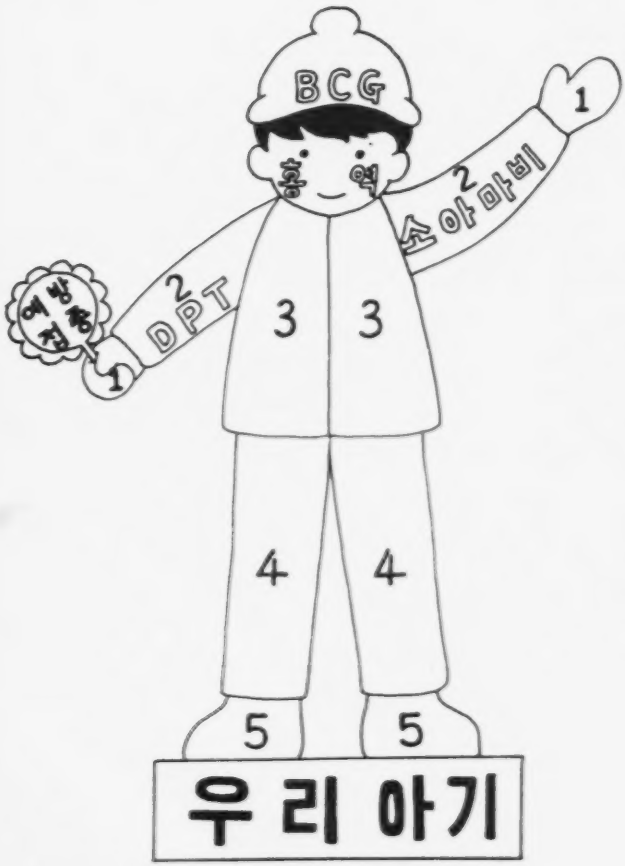
Two further general points can be made at this stage. First that an informed user group can pressure on the "establishment" to provide the services which they want. Examples of the politicized user seem quite rare in development work in Asia, but they are growing in number. The best example may come from breast-feeding promotion campaigns in several countries where mothers have demanded their rights to "rooming in" and to feeding their children themselves.

A second point which arises from our analysis, to be pursued further in the next section, is that health communication is not exclusively a matter for the health staff to pursue. Effective communication cannot be confined to a specific sector if it is truly audience-based.

Last but not least, how do we involve in communication for EPI other government and non-government agencies who are reaching the same group of mothers? And, how can we involve the modern and indigenous media for wider coverage? (Nor should we forget health personnel beyond the immediate bounds of the EPI -- e.g. family planning workers, nutritionists, sanitarians, PHC workers, etc. In a typically vertically structured Health Ministry they may have as little knowledge of EPI as would officials from another Ministry. Unofficial health workers, such as Traditional Birth Attendants (TBAs) may also be an important source of communication -- particular on the need for neo-natal tetanus injections.)

Typical of other sectoral agencies to be involved, however, might be the Ministry of Education, personified by the village school teacher at the local level; the Ministry of Agriculture represented by the agricultural extension officer or the Ministries of Community Development and Social Welfare also with officers at the village and district levels.

NGOs who may have easy access to the village, or commercial channels -- travelling sales men in food or drugs -- may also be considered. As we see the list of potential channels to use may be almost infinite. How do we reach these media to involve them? There are many ways. Providing them with materials to distribute is one; inserting appropriate components in their training courses or manuals e.g. EPI for traditional birth attendants is another.



Immunisation chart used in the Republic of Korea

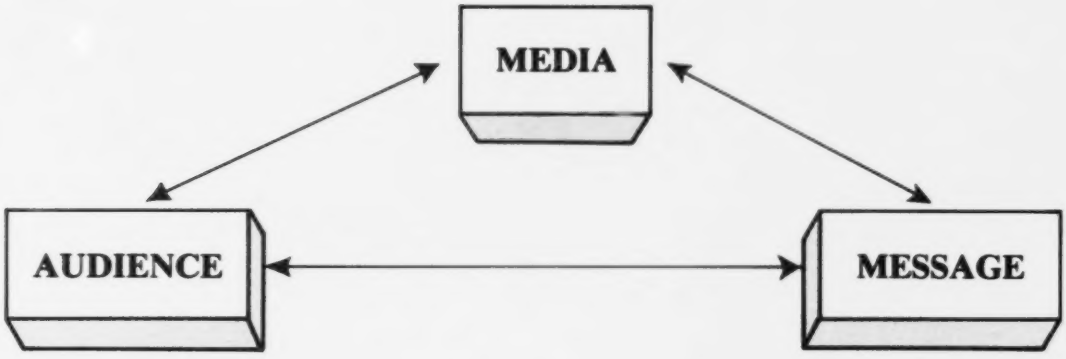
What are the constraints to their involvement? The major constraints after official approval has been granted by the authorities concerned may be the very real constraint -- that people cannot and will not take on extra tasks unless it enhances their existing performance (for which they are being evaluated) in a significant way. Enhancement may take various forms. To take an extreme example, some religious leaders whose spiritual power is declining in the face of advancing modernity may be prepared to take on other roles, in development work for example, to refurbish their power in the community. One of the most successful examples of cross-sectoral involvement in the EPI field has been the use in some countries of village school teachers and their pupils to monitor the vaccinations of younger children. This has been done by making a segmented drawing of a child and progressively colouring in the segments as successive immunizations have taken place. In this way the older children are involved in reminding their mothers of actions to be taken.

How do we involve the mass media in health promotion and what role can they play? increasingly journalists and television and radio producers and writers are being asked to play a role in health promotion activities. And indeed they can play a major role by reaching a large number of people in a very short time. It is now quite common for development agencies to fund "roundtable conferences" between health officials and media personnel to persuade the latter of their important role in changing public opinion and to brief them on the health interventions they would like promoted.

What are the usual limitations on participation by these audiences in such a programme? The main ones from our point of view are that they need to be paid for their space and time. And that secondly, the content with which we are concerned -- e.g. EPI, ORS -- may hinder true creative expression as they see it. Journalists or radio and television producers may be valued for their individuality and original views which promotion of certain health innovations may not allow free reign.

3. SELECTING APPROPRIATE MEDIA FOR DIFFERENT GROUPS AND DIFFERENT PURPOSES

The next brick in the wall is MEDIA selection. Selection of a MEDIUM, or a group of MEDIA is based on consideration of the characteristics of that MEDIUM/A; the characteristics of the audience; and the nature of the communication task or tasks required in particular circumstances.



In general, we can state that effective communication can only be conducted through a MEDIUM or combination of MEDIA which allows for dialogue and exchange -- otherwise known as two-way communication.

To address a woman's fears and misunderstandings about EPI, for example, we should choose MEDIA/a MEDIUM which would allow questions and response as well as conveying knowledge and information. For this purpose, a well-informed, well-trained, motivated and empathetic human being, who is sensitive/sensitized to the mothers' concerns is the best communicator. Such individuals may, however, represent only a small percentage of the available resources! We mentioned earlier the use of "satisfied acceptors" to motivate potential beneficiaries. This is a technique, most frequently used in the population field, whereby acceptors or adopters of an innovation are systematically used to persuade their peer group that they should follow suit.

Even the best human communicators may also need audio-visual support (reference manuals, models, charts, etc.) to remind themselves of the information or skills they have to impart, and to assist them with their explanation. At the risk of repetition it must be said that all aids must use language and visuals comprehensible to the audience. This involves a good knowledge of the audience skills in these areas, based on baseline analysis of those audiences as well as on pre-testing early versions of the material and MESSAGES.

It should be mentioned here, of course, that different MEDIA as well as differing in accessibility may be valued by a particular audience for different purposes. This means, for example, that folk MEDIA may or may not be acceptable for conveying developmental MESSAGES if their use relates only to the maintenance and restatement of traditional cultural values; that the use of religious leaders may or may not be acceptable and effective for endorsement of health or nutrition MESSAGES, even though they are routinely engaged in

"extra-mural" activities such as commentary on domestic politics, or settlement of village land disputes; that radio or television may be used only for entertainment and not for learning, and so forth. Often the use of a new and "foreign" MEDIUM such as television, or even films in some areas, may be its own MESSAGE. The "content" is overwhelmed by the glamour of the packaging and presentation. This is said simply to underline the fact that it is necessary to determine during communication strategy planning, which MEDIUM or MEDIA are the most appropriate from the audience point of view for each particular task. Under the term "appropriate" we include accessible, believable, and allowing for dialogue and participation. One cannot assume in advance of detailed audience analysis which MEDIUM will be most appropriate.

The limitations of the mass media for programme communication purposes are inherent in their major strength which is in reaching many people simultaneously with a uniform message. This means that messages which are audience-specific - in terms of geographical, or linguistic coverage, or in terms of the timing of the message relative to the arrival of services (e.g. information about the availability of immunization services)- can rarely be relayed through the mass media. The exception to this, of course, would be where production either of newspaper or radio and television is very localized.

Another limitation on the use of these media is the relative difficulty of building in audience feedback. Again, this difficulty is lessened where the media are de-centralized and it is possible to obtain some response in the form of video or audio-taped interviews with members of the audience which can be used in programmes, or by encouraging readers to write or even phone.

A further word on the third corner of our triangle; are particular MEDIA particularly suited for particular

"Posters do not always speak for themselves."

information/communication tasks? The short answer is, yes! Posters, despite their great and continuing popularity -- for many people communication is posters -- are actually of very limited value on their own. They cannot speak and do not listen. A poster could be used for a simple statement which will stand on its own -- Immunization Services Are Available Here -- or to repeat,remind, highlight points from other communication efforts. Billboards and even radio spots can be used the same way. Even the example given above assumes that the reader has already gained a lot of information from elsewhere; that they already know what immunization is and why they should have it; it assumes that they can read, and, that they are at the clinic already.

What are different media good for? How best can they be combined?

For some communication tasks where a process is being taught -- e.g. performing a vasectomy -- it is clear that a MEDIUM which can show movement would be the correct choice. Recently video-tape has acquired great popularity in this area as the tape can be stopped, played backwards and repeated according to the needs of the audience. Use of video-tape, of course, also presents many problems particularly in under-electrified areas but these and related issues will be dealt with in more detail in a separate handbook on MEDIA selection where we shall also consider that important variable, cost.

Finally, a word on the durability of the information to be communicated. How long will the information be valid and current for this audiences? Do they need essentially the same information in progressively more detailed doses? How changeable are the technical and domestic terms used in this subject area? These are some of the questions to be answered before we begin massive investments in printed materials which may have to last from three to five years. In such cases it might be wise to invest a more "ephemeral" MEDIUM such as radio as well as to budget for frequent periodic up-dating of our human MEDIA through refresher training.

4. OVERALL COMMUNICATION STRATEGY DEVELOPMENT

By following this systematic planning process we should now have assembled the main building blocks of our communication strategy.

AUDIENCES
• We know whom to address, and in what order.
MESSAGES
• We know what advocacy, information, skills training, orientation, each audience needs in order to participate in the programme.
MEDIA
• We know which channels we should use for each audience and information task.

All that remains is implementation! What do we need to do to turn these blocks into wheels?

A priority throughout the planning and the implementation of a communication strategy -- and one about which we should remind ourselves here -- is to keep constantly informed about the development and phasing of other programme components. It is not simply a question of phasing communication inputs accurately, relative to each other, announcement of vaccination clinic times should not take place before other needed information/motivation has taken place, for example; people should not be trained for tasks which do not yet exist, both communication hardware and software are equally needed and should be compatible. Though this phasing is very important and frequently overlooked.

But we must also be very careful about the phasing of communication and other programme inputs which is equally critical, and equally often disregarded. The delivery of EPI services and the creation of demand for those services, for example, should be carefully timed. Mis-timing results in a dissatisfied consumer group who cannot find what they want at the health centre or alternatively with trained and equipped health staff who have no one to vaccinate.

Another important general issue with which we have not dealt directly here relates to the clear definition of responsibility for different tasks, and precise budgetting for each activity. Too often communication planners forget these details as to who will do what they have planned, and where will the money come from. Particularly where the need for communication is not yet well-accepted it is not unusual to find that there is no special budgetary provision for these activities which are perhaps assumed to take place automatically or in the course of other less "peripheral" activities.

To briefly run through the other major wheels on which implementation of the project turns.

- Production of Audio-visual Aids
- Audio-visual Equipment Specification and Procurement
- Plan for Co-ordinated Distribution and Usage of Audiovisual Aids and Audio-Visual Equipment (and spare parts)

The major point to be made here as we shall be discussing production techniques in more detail in another Handbook is that all these activities are interdependent and inseparable although frequently

conducted independently. This is often an organisational problem. The Unit which produces slides and photographs, may be different from that responsible for equipment specification and procurement. All to often equipment specification is a matter of opening a manufacturer's catalogue to check the price of the latest model available. It should, however, be viewed programmatically, i.e. in its overall programme and country context. Will the equipment in question be able to cope with prevailing climatic condititons? Are spare parts easily available? Who will provide these during and beyond the life of the programme? Is there electricity if electricity is needed? In what type of building will the equipment be used/stored? Are the individuals who will use and maintain it technically equipped to do so, and aware of their responsibilities? Who will be accountable? Is the number of items ordered realistic? Is the appropriate software" when developed going to be distributed to the same points as is the "hardware" and with sufficient copies?

The checklist of questions to be asked and answered is almost endless. The point to be made here is that these are questions often not

"The supplies approach to communication."

raised. It is easier to produce a-v aids and to buy equipment than it is to plan for their precise and co-ordinated distribution and utilization. It is another aspect of our ignoring the users in favour of a top-down "supply" approach to communication.

Training is an important part of the communication process. It is also important to review and analyse the training components of the programme as a whole. Our ultimate objective may be to train mothers in better child-care skills, but that in turn may involve teaching health-workers, both in the needed skills and how to communicate them. To ensure the budget for this health-worker training we shall perhaps have to inform and orient the decision-makers in the medical establishment about the new thinking on child care and so forth. Perhaps we shall even have to send some of them on a study tour to observe a similar programmes in operation elsewhere. It is vital to connect each link in the chain of communication and training.

The effectiveness of our communication plan may also require other types of training. Perhaps we shall have to train some of our "creative" people to relate their audio-visual materials to the audience,by using available data on the audience in the design process, and by pretesting their preliminary products.

Again, as indicated in the preceding section the users of our audio-visual aids and equipment may need training in their usage and routine maintenance. The message is the same. We have to think of all the communication/training links needed to ensure that the programme indeed reaches the user. And these activites must be integrated at every step with other components of the programme.

It is useful to view these activities as a continuum in developing and implementing our communication/training strategy as each activity is a mechanism through which we check with our user audience on the appropriateness of the programme to their various needs.

We have discussed extensively in earlier sections the **"research"** data which we need from and about various "audiences" as a basis for programme communication planning. We need to know, relative to our planned intervention, (EPI, ORS, breast-feeding) What people are doing now and why they do that. This information is of value both for programme service, and programme communication strategy design. More narrowly relevant to the communication field in that it relates directly to message design and media selection is the data we need to gather on the communication behaviour of our different audiences. What language are they comfortable with? What visuals do they understand, and do different colours have different significance? What media are accessible and familiar to them? To whom do they speak,?To whom do they listen and for which types of information? But, again, this data must be combined with data based on programme content to form the correct messages.

We have earlier avoided the use of the word "research"; and deliberately so. Many non-experts in the field find the prospect so alarming that they would prefer to ignore its existence and the need for it. The kind of research we are discussing can be done with great pomp -- foundation grants, computers, an army of investigators. But that is largely a question of style! And the requirements of the Ph.D. Committee.

Anyone involved in a programme of communication for EPI can identify data or research needs by asking themselves "What do we need to know about the constraints against mothers bringing their babies to be vaccinated even when the services are available?".

If we are promoting the EPI it is only common-sense to ask this and other questions as listed on page 11. Similarly there are common-sense ways of finding the answer? For various reasons to be further explored in another Handbook semi-literate over-worked, poor

"We need to know about existing child-care practices."

rural mothers tend not to respond very well to questionnaires adiministered by government officials, students or hired researchers! In obtaining communication from our audiences we should bear in mind the principles we apply when communicating to them -- particularly the credibility and acceptability of the various channels which reach them. We can and must use these channels to obtain information from our audience. For example, Traditional Birth Attendants (TBAs) or peripheral health-workers may be able to tell us in great detail about their clients' health practices. To talk to or interview them may be quicker and more economical than surveying mothers and the data may be more credible and objective as they are not talking about themselves! Self-reporting is notoriously unreliable! Also people who are in but not of the community are less likely to be disturbed by contacts with outsiders, such as any interview process, however informal, would involve.

Another important "research" activity following at a later stage in programme development is the pre-testing of "mock-ups" of audio-visual materials for their comprehensibility and acceptability to the intended audience of users. This again is an important and often neglected aspect of our work - which needs to be planned and budgetted for and to be conducted by a person not only skilled, but also committed to the exercise of listening to other people's views.

The conduct of **monitoring** and **evaluation** of activities does, of course, depend entirely

on one's having established the baseline situation and on having defined a series of objectives, and indices of achievement of these objectives against which to measure actual progress. We have mentioned above the measurement of acceptability of our audio-visual materials. We should also have a series of other objectives, achievement of which we can evaluate in various ways. For example, we should target:

- how many mothers should be reached by a certain number of messages in what sequence and with what time-frame?
- how many books/pamphlets/posters should be produced by a given date?
- how many should be distributed at each level/geographical area?
- how many items of each piece of equipment should be distributed and installed at specific sites?
- how many vaccinators should receive communication training?

The attainment of this type of quantitative objective has to be supplemented, of course, by some other information e.g.

- how many mothers actually read and understood the pamphlets they received on EPI (breast-feeding, ORS);
- how many vaccinators retained and conveyed the substance of their communication training.

"It is important to know about actual usage of materials as well as their distribution."

And we have still not measured the impact of all these activities in terms of actual behavioural change of our primary users.

e.g. . how many mothers acted on this information and submitted their children for vaccination.

We can see that even if we try to restrict ourselves to communication and training there are many measurements we should take if we are to have a good idea of the effectiveness of what we do. Our colleagues in other fields will be measuring the achievement of their input and output, and impact objectives also and somewhere the Great Evaluator should put these all together and see whether the project "worked'!

There is a danger, of course, that so much energy is expended in evaluation that implementation actually suffers. We shall review this and other methodological issues in Handbook 7. Again, like other "research" activities evaluation is largely common-sense! This applies even to impact evaluation which is by far the most difficult evaluation to make. We must keep asking ourselves what happened to our audience when we did that? Why did they do that?

Impact evaluation is relatively easier when it involves measurement of acquisition through training of simple skills e.g. Can the mother mix Oral Rehydration Solution; Can the health-worker use a flip-chart? We shall discuss in detail in Handbook 7 the various methods which can be used for impact evaluation.

Here in closing, I would like to mention a limitation on measuring the effects of communication inputs in a project in terms of changes in behaviour of our audience. Many programme and non-programme factors have impact on behaviour. Communication if it is to be effective must be integrated into the programme or project. The only way of isolating the effects of that input are through complex experimental designs using treated and untreated groups who must in all respects be comparable,other than in their communication exposure. A similar difficulty arises if we are to try to compare relative impact of different media inputs. Needless to say, this process is time-consuming and expensive, and rarely practicable in the real world. The overall effects of a programme should indeed be evaluated wherever possible, but for the communication component the ongoing and interim measurement would seem to us to be more important and realistic. We must start by listening, and continue to listen otherwise we cannot really communicate anything at all.

SUMMARY

Let us summarize the main points of the programme communication approach we have been advocating here. These are that:

- communication does not automatically take place with provision of the services. Different communication inputs. must be planned in advance and properly phased relative to other aspects of the programme and to each other;

- several different groups must be reached and involved if the intended "beneficiaries" are to participate;

- information from and about these groups, their characteristics, their current beliefs and behaviour, is needed to help shape the programme overall, as well as the communication inputs themselves;

- the channels or media used must be carefully selected according to specific functions and specific audience addressed. The media or combination of media used must allow the "audience" to also speak back if there is to be real communication and dialogue;

- to communicate means to participate, to share. If we keep this in mind we can see that this belief in twoway communication underlies the total programme communication strategy.

from the programme side we have a new skill or idea to bring to our audience but we must listen to their views on this, and find out what they are doing now and why they are doing it. We know what different media can do but we must find out from our audience to which media they have most access, what media they like, which do they believe in.

finally, when we have the programme and the communication element established and under implementation we must continue systematically to monitor and evaluate the response from our audience. We must listen as well as speak.

GLOSSARY

Demand - Creation.
Service - Delivery : These terms are taken from the family planning/population field where the complementarity of programme (i.e. delivery of services) and Information/Education/Communication (IEC) for the purposes of demand-creation were recognised very early.

Satisfied Acceptors : A term borrowed from the family planning communication field where acceptors of family planning methods (pill, IUD, tubal ligation, etc.) who were pleased with their decision were used extensively to motivate others.

Imams : Muslim religious leaders

Primary Audience : The group of people intended to be ultimate users and beneficiaries of the project.

Secondary Audience : Groups of people whose informed involvement is also necessary for the effective involvement of the user group (primary audience)

Indigenous Media : Media and modes of communication indigenous or native to a particaular population (e.g. shadow-plays in Indonesia, Chinese Opera, etc.)

Software : As in communication software; e.g. film, audio-tape, those elements which need to be replaced continually.

Hardware : As in communication hardware; e.g. equipment such as a camera, a projector.

Mock-up : A mock-up of a poster is an initial or preliminary design/model to be tested before full production.

Treated Group : As in an experimental situation, the group subjected to the experimental input e.g. video programmes on EPI. Relevant changes in the treated group after this input (e.g. with respect to knowledge of immunization) are compared with knowledge levels on EPI in the group not treated (i.e. untreated) to assess however roughly the effects of the video programme input. For the ideal experimental situation the treated and untreated groups must be similar in all respects other than their relative exposure to the video programme on EPI.

REFERENCE MATERIALS
ON
PROGRAMME COMMUNICATION

REFERENCE MATERIALS ON PROGRAMME COMMUNICATION*

The attached reference materials summarise or illustrate by live examples some key points in the text. They may be helpful when explaining programme communication -- with specific reference to EPI -- to other colleagues inside or outside UNICEF. Several of them can be converted into overhead transparencies.

Reference Material 1: KEY QUESTIONS TO ASK WHEN DEVELOPING A PROGRAMME COMMUNICATION STRATEGY

Reference Material 2: IDENTIFICATION OF AUDIENCES FOR AN EPI

Reference Material 3: PROBLEM ANALYSIS, POSSIBLE CONSTRAINTS ON AUDIENCE PARTICIPATION

Reference Material 4: PROGRAMME COMMUNICATION FOR EPI : INDICATIVE MATRIX

Reference Material 5: EXERCISE FOR DEVELOPING COMMUNICATION MATRIX FOR EPI

Reference Material 6 POSSIBLE TYPES OF COMMUNICATION MONITORING AND EVALUATION TO BE CONSIDERED.

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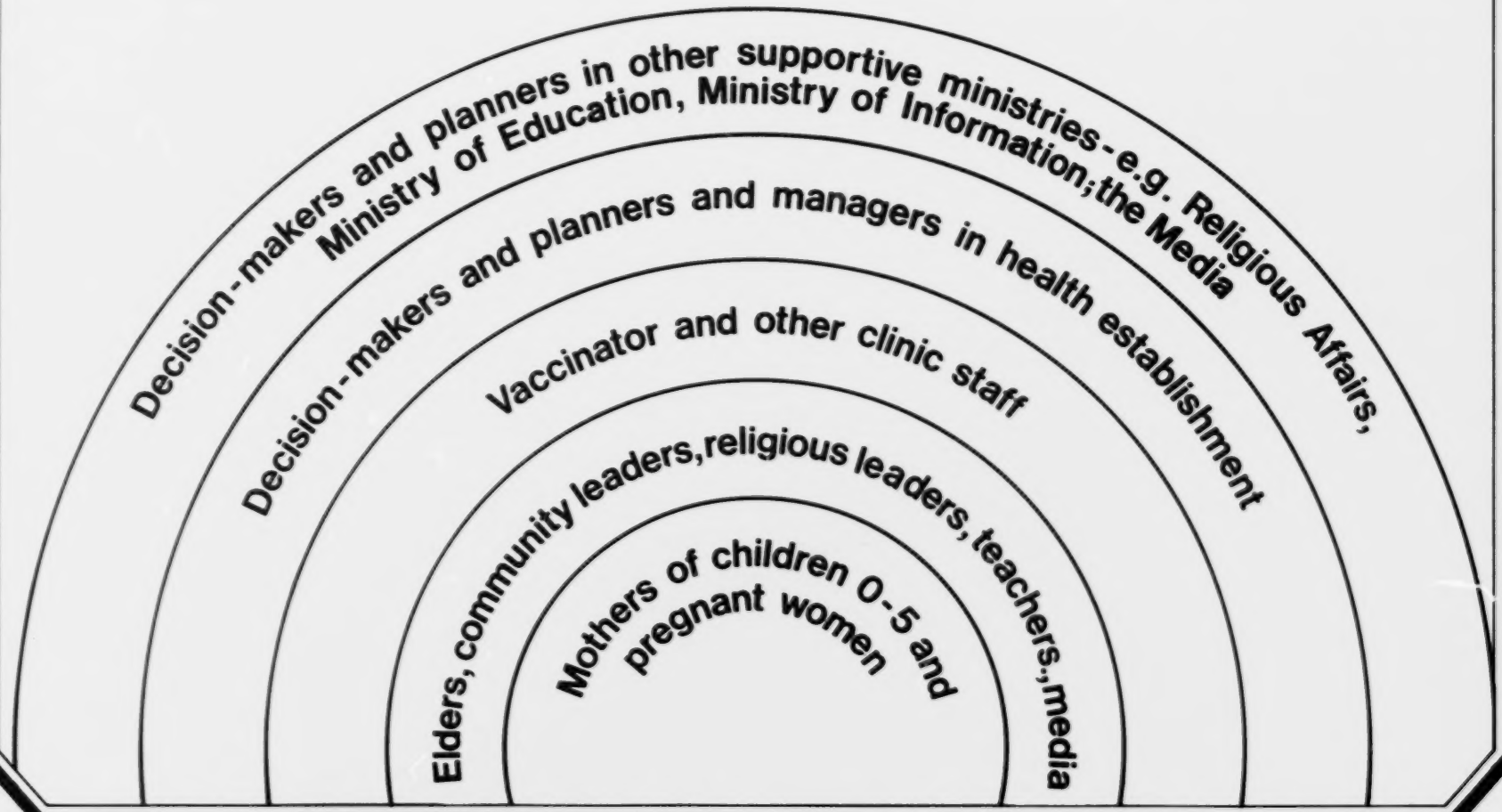
* *Colleagues who would like to contribute new examples from their own experience should forward them to the PSC and Training Section,* **UNICEF-EAPRO, Bangkok,** *for printing and distribution. All sources will naturally be acknowledged.*

KEY QUESTIONS TO ASK WHEN DEVELOPING A PROGRAMME COMMUNICATION STRATEGY

- TO WHAT GROUPS OF PEOPLE?
- WHERE?
- IN WHAT ORDER OF TIME?
- MUST WHAT SPECIFIC INFORMATION AND TECHNIQUES BE CONVEYED?
- BY WHAT MEDIA?
- WITH WHAT SPECIAL INFORMATION MATERIALS AND AIDS?
- PRODUCED BY WHOM?
- WHAT WILL THIS COMMUNICATION COST?
- IS THIS COST BUDGETTED FOR?
- WHAT ARE THE INTENDED EFFECTS?
- HOW WILL THE ACHIEVEMENT OF THESE BE EVALUATED?

IDENTIFICATION OF AUDIENCES FOR AN EXPANDED PROGRAMME ON IMMUNIZATION


Decision-makers and planners in other supportive ministries - e.g. Religious Affairs, Ministry of Education, Ministry of Information; the Media
Decision-makers and planners and managers in health establishment
Vaccinator and other clinic staff
Elders, community leaders, religious leaders, teachers, media
Mothers of children 0-5 and pregnant women

PROBLEM ANALYSIS, POSSIBLE CONSTRAINTS ON AUDIENCE PARTICIPATION

(a) Mothers/fathers

- Do not recognise symptoms as indicative of particular diseases;
- Do not know these diseases are preventible;
- Already follow folk remedies/visit traditional, medical practitioners;
- Believe that injections are only for cure not prevention;
- Have had previous negative experience with EPI programme;
- Only visit clinic when sick;
- Health personnel have low credibility/popularity/mobility;
- Know about programme but do not understand schedule;
- Cost of services too high;
- Clinic too far away.

(b) Health staff with immediate access to community

- Not well-informed about EPI (symptoms of diseases; schedule of vaccinations, etc.);
- Not informed about community information needs and fears; do not know about necessity to address these concerns;
- Too busy to actively promote EPI; follow-up for booster shots;
- Not supported by supervisers in health education work;
- Do not see "communication" as their concern, nor helpful to their work;
- No travel budget, etc.

(c) Medical Establishment

- Not informed about constraints on programme from the "demand-creation aspects";
- Do not know how to address these in term of e.g. supporting additional training for lower levels of health personnel who deal with the community; providing budget and, if possible, expertise to implement communication activities through other channels.

PROGRAMME COMMUNICATION FOR EPI: INDICATIVE MATRIX

This matrix was developed during the analysis of communication needs of an EPI in one country in the Region. To be completed are the columns on Institutional Responsibility and Budget.

PROGRAMME COMMUNICATION FOR EPI: INDICATIVE MATRIX

Target Groups	Behavioural Objectives	Messages to be developed	Communication channels	Needed Actions	Institutional Responsibility	Budget
Mothers/fathers of Children 0-5	. Submission of Children to complete cycle of vaccinations.	. Information as to relationship between prevalent childhood, diseases and vaccination; corrective information to negative rumours; information on conditions of services/staff.	. Village Health Communicator . Family Welfare Worker . TBS's, Dais, etc. . Clinic, hospitals	. Analysis of audience knowledge, response to fears of EPI . Selection of appropriate channels . Appropriate preparation of those channels through training, supporting materials, etc.		
Pregnant women/ their husbands	. Submission of women themselves for neonatal tetanus vaccination	. Benefits of vaccination and condition of services (periodicity, time, location, etc.)	. Other local leaders (imams, teachers) . Extension staff . Other sectors . Mass Media campaigns . Demonstrations	. Involvement of other ministries (beyond Ministry of Health) . Involvement of NGOs		
Vaccinators	. Improve their understanding of need to motivate mothers/ fathers and improvement of their skills to do so.	. Provide information of target audience concerns and fears and how to cope with them.	. Training courses on the job orientation.	. Develop modules to train and orient vaccinators; develop neces sary training and extension aids		
Related health and health communication cadres	(as above)	(as above)				
Other extension cadres (imams, teachers, etc.)	(as above)	(as above)	. Orientation briefings;module on EPI communication in on going training programmes	. Develop modules . Inserts in professional publications;Mass Media		
Decision-makers and Managers in EPI in MOH	. Understand and support communication programme.	. Information as to audience needs and needed communication activities	. Meetings, Seminars, Mass Media	. Development of appropriate presentation and articles, etc.		
Related Ministries	. Understand their role in EPI communication	(as above)	(as above)	(as above)		

EXERCISE FOR DEVELOPING COMMUNICATION MATRIX FOR EPI

This exercise was used in a project development workshop in one country in the Region.

PROGRAMME COMMUNICATION MATRIX FOR EPI IN COUNTRY X

National or long-term objective -

To reduce mortality rate of children in the age-group 0-5 by 30% within the Five-Year Plan period (1980-85) by strengthening and expanding preventive and curative health services to this age group through the health system and other channels.

EPI Programme Objective or Immediate Objective - to be achieved within the life of the programme

To undertake a second strengthened phase of the Expanded Programme of Immunization phased on a geographical basis, to reach 6 million children in 0-5 age group within a three year period achieving 2/3 of that target in the first year.

Suggested Communication Matrix for EPI (Fictional Country)

It should be noted that the attached matrix is a suggested format intended to assist the process of analysis. It is not a definitive format to be memorized. It is possible to change the categories and items in these boxes; to change the order of presentation etc. Similarly, we should not be alarmed if a set of people regarded as a channel in one column becomes an audience in the next. This change is conditioned by the function and point of reference. The same is true of those problematic items, objectives and activities; a single item may have either of those labels depending on the reference point from which it is viewed.

The design and implementation of the communication input is of course conditioned by the nature and effectiveness of the service-delivery side of the programme.

The precise phasing of communication inputs relative to each other and to other programme elements is extremely crucial.

draft

a. Audience Category	b. Learning and Behavioral Objectives	c. Medium of Communication	d. Activities Needed	e. Institutional Responsibilities
1) Primary Audience Parents of children in 0-5 age group (according to geographical phasing)	- to understand major causes of child sickness - To understand relationship between immunization and improved health (in context of overall preventive health care) - To understand conditions of service delivery (time, location, cost periodicity, side effects, etc.) - To submit their children for the full cycle of vaccination - To become a positive influence in the community with respect to EPI.	- satisfied acceptors - village leaders - traditional birth attendants - community health workers - health service staff (mobile and static services) - extension agent from other sectors as appro priate (teachers, agricultural extension) - religious leaders - local media groups - mass media through local programming	(in addition to strengthening EPI delivery system) - Audience analysis & needs analysis to be conducted locally by trained local leaders (teachers, village level officials, etc.) to ascertain level of knowledge of EPI and acceptability of services; to assist selection of other media approaches (as in c.) - Orientation of interpersonal communicators (c.) to benefit of EPI and conditions of services; training in involving community and development of extension aids if necessary - Developing mass media activities on localized basis using interpersonal communicators as resource persons for programming	- Dept. of Local Govt. - Community development - Ministry of Health - Local radio stations and newspapers - Organizers/managers of local media troupes - Other sectoral ministries involved

b). Audience	Learning and Behavioral-Objectives	Medium of Communication	Activities Needed	Institutional Responsibility
Extension/Communication System				
- Satisfied Acceptors - Village leaders	- To understand conditions of present EPI and to realize the importance of promoting it to others in the community	3-5 days orientation and training course (on EPI and communication/promotion skills) simple a.v. aids as necessary.	- Training trainers as necessary - To develop at village level simple training programmes with appropriate aids as necessary; provide for training follow-up and evaluation through informal survey and through clinical records; to encourage feedback from this audience for developing mass media and overall programme activities	Dept. of Local Govt.
- TBAs	- to dispel negative rumors	- do -		
- Community Health Workers	- To understand current community attitudes to EPI; to promote EPI to community; to dispel misinformation	- do -		Ministry of Health
- Health Service Staff	- To appreciate community attitudes and to provide motivation for EPI along with appropriate services	Modules on audience analysis and communi cation skills in on-going training programmes	Development of Learning Modules and aids within on-going training programme	Ministry of Health and Sectoral Ministries
- Extension Agents (other sectors)	- To understand benefits and conditions of EPI and to promote it to their clientele	Modules in EPI, benefits, condition, current acceptability		
- Mass media organizers	- To understand present EPI and to provide information as to services.	Meeting with local mass media organizers, programmers, journalists	Development of programmes in cooperation with and supportive of local change agents.	
- Local media Troupes	- To understand EPI and community attitudes; to promote EPI and dispel negative rumors	Meeting with local media troupes	Intervention of EPI motivation and information messages	Ministry of Information

c) Planners and Decision Makers	Learning and Behavioral Objectives	Medium of Communication	Activities Needed	Institutional Responsibilities
- Sectoral Ministries secondarily involved in EPI (e.g. Dept. of Local Govt.; Education, Religion; Agriculture, Information, etc.)	To understand present EPI programme; To appreciate negative community attitudes to previous phase and the need to involve them in present phase. To understand their role in supporting training extension agents, change agents, etc.	Meetings as organized by MOH and Planning as focal points Information Materials; Radio, television, newspaper coverage; Field visits as appropriate	Scheduling and organization of meetings at appropriate time in programming and implementation. Developing materials for different groups Ensuring mass media coverage. Organizing field visits.	MOH and Planning Commission
- Private sector (e.g. advertising and mass media services.)	To provide supportive coverage as required.	Meetings and briefings; field visits.	Organization of meetings, briefings, field visits.	MOH and Planning Commission

POSSIBLE TYPES OF COMMUNICATION MONITORING AND EVALUATION TO BE CONSIDERED

Some types of monitoring and evaluation to be considered.

MONITORING AND EVALUATION

- Message/materials testing in the course of development
- Evaluation of dissemination and utilization against original plan
- Impact Evaluation:
  - Comparison of treated/untreated areas
  - Sample survey of population concerning communication received
  - Before/after measurements at service points
  - Questioning of users at service points.
  - Informal questioning of key personnel e.g. health staff
  - Training course evaluation; skills acquired; skills utilized
  - Further actions of decision-makers in support of communication activities
  - Sustained behavioural change beyond programme life

IDEAS ON HOW TO USE THE SLIDE SHOW ON EPI

This short slide show is meant to be an introduction to discussion and/or group work. It raises a common problem in EPI - a problem that can be caused by a number of factors, e.g.

- lack of proper planning;
- lack of concern for the villagers' traditions, knowledge, attitudes, and communication behaviour;
- lack of involvement of community leaders;
- lack of training and motivation of health trainers, field workers and vaccinators (especially in communication techniques), and lack of concern for their time and budget constraints;
- lack of understanding of and concern for the community's involvement by the decision makers, and lack of emphasis on health education/communication aspects for health workers by the same group.

The text in the first EAPRO handbook and the various annexes will provide you with background materials for how to analyse problems concerning the above areas. This can be used in combination with the slide show for audiences such as:

- The PSC officer with his or her staff, as a training exercise.
- The PSC officer (and staff) with project/programme staff in health/nutrition, to discuss communication support for EPI and/or other programmes.
- The PSC officer (and/or programme/ project staff) with Government officers, in workshops/meetings to discuss communication support for EPI and/or other programmes.
- Health education trainers (or national PSC officers) with field workers and/or vaccinators, to discuss problems and solutions in the EPI.
- PSC officers or health/nutrition officers with physicians to raise awareness of the need for more emphasis on health education/communication in EPI.

When using the slide show, you may try to adapt the situation to your country. And if the models in the slide show are very different from the people in the country where you work, you may try to shoot your own series of slides to avoid identification problems. Such problems (your audience disregarding the problem you present because they claim it does not exist in their culture) may arise if you are using the series with field workers, but is less likely to occur at higher levels.

Before using the series, you should investigate carefully the situation in your country. If you don't know the answers to questions health professionals and planners may ask, your credibility as a communicator will be lost, and neither the slide show nor your group exercises and discussions will have any impact.

Suggestions for discussion topics:

A Development of a communication component for EPI, including:
- identification of audiences
- questions to be asked in the community
- setting learning objectives and deciding messages for each audience
- decide through which media you will reach them

Put the information together in a communication matrix

B What is the effect of different media (interpersonal, printed, projected) on villagers' behaviour, e.g. on deciding whether or not to have their children immunized?

C Analysis of constraints of the different target groups (i.e. what prevents them from adopting the behaviour required for the EPI to function smoothly?):
- Mothers of children 0-5 years, and pregnant mothers. (e.g. mother in law, husband; traditions, workload, inaccessible health post; unfriendly health worker/vaccinator, previous experience with the programme etc)
- Community leaders, religious leaders, teachers etc.
- Vaccinators and other clinic staff
- Decision-makers, planners and managers (health establishment)
- Decision-makers and planners in other ministries.
- Media.

D To whom does the mother communicate in the village regarding questions on health for her child? Who are the "credible sources"? What and who influences the mother's decision to go to the health post? What kind of influence do the various people have on the mother regarding her health behaviour? What kind of influence does the health worker have?
What are the implications of these issues on the programme planning for EPI, and on the communication component in particular?

E What does the average village mother know about immunization, its preventive effect, the relationship between childhood diseases and vaccination, the side effects, the schedule of vaccination, the timing, location and cost of services?
(NOTE: if you use this question with planners, decision-makers health trainers, physicians or field workers/vaccinators, you may discover interesting communication gaps between the opinion of these groups and the real situation in the field. This information may help you in planning ways to bridge the communication gaps.)

F What are the advantages of using media (in this case a slide show) as an introduction to discussion, rather than as a channel to disseminate information? What are the disadvantages?

PROBLEM FOCUS ON EPI:

DRAFT SCRIPT - SLIDE SHOW

WHY DID THE MOTHER NOT COME BACK FOR HER SECOND DPT SHOT?

1. Every new baby that comes into the world is welcomed by its mother.

2. A healthy, happy baby is every mother's wish.

3. The whole family is usually involved in caring for the welfare of the baby.

4. The young mother discusses the baby's health with the elders in the family. She listens to their advice - they have experience, and have successfully brought up many children.

5. She also discusses the baby's health with neighbours. The people she listens to are especially other women with babies, those women who have a certain influence in the community because of their knowledge about health matters. She also listens to community leaders, and to school teachers,
Today, the topic of discussion is immunization against childhood diseases. The mother decides she will go to the clinic to have her baby vaccinated.

6. At the health post, she sees a poster with pictures of sick children. But - she is illiterate, so she cannot read the text. She is too shy to ask the health worker what the poster means.

7. The mother joins the queue waiting for the immunization. It takes about an hour before it is her turn.

8. The nurse gives the baby a DPT shot,

9. She explains that this will protect the baby from diptheria, whooping cough and tetanus. She says the mother has to come back for a second and a third shot for the baby. The whole"operation" takes less than five minutes.

10. The mother goes home. After a couple of days, the baby develops a fever.

11. The mother is worried, and she correctly assumes that the DPT shot has caused the fever.

12. She makes traditional medicine for the fever. She grinds the bark of a tree with some water to a fine paste.

13. She applies this paste to the baby's head, and keeps him in the sun.

14. The grandmother rubs the baby with oil to ease his discomfort from the fever.

15. The baby is improving, and a couple of days later he is well and happy again.

16. The grandmother and the mother decide not to go back to the clinic for more shots. They do not want the baby to get sick again.

17. The health worker has checked the card and discovered that the mother has not brought the baby back for the second DPT shot. She is angry, and blames "these ignorant mothers" who do not know what is best for their babies.

18. The nurse and the mother. Whose "fault" is it that she did not come back?